Chiropractic Sports Medicine

24741 Alicia Parkway, Suite D
Laguna Hills, CA 92653

Payment Policy

It is the policy of Chiropractic Sports Medicine to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card and/or complete billing information is required and must be presented before services are rendered.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Chiropractic Sports Medicine does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan *before* services are rendered. This also applies to any facility or provider that your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays or deductible amount, non-covered services, services deemed by the insurance company as not medically necessary, doctor non-participation in a plan or any other reason for non-payment or reduced payment is the responsibility of the patient or responsible party.

HMO's and other insurance plans that require authorization for treatment from the Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered. Authorization does not guarantee payment by the insurance company.

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Patient due balances over sixty days old will be subject to late fees. Delinquent balances may be referred to an outside agency for collection.

I have read the above policy, and understand that I am financially responsible for all medical services rendered.

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Signature of Patient or Responsible Party Date

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Print Name